



## **Referral Form - Occupational Health Assessment**

Company Name: \_\_\_\_\_

Company Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Contact Name: \_\_\_\_\_ Tel No: \_\_\_\_\_

Contact email: \_\_\_\_\_ Date of referral: \_\_\_\_\_

PO Number: \_\_\_\_\_

### **Employee Details:**

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Tel No: \_\_\_\_\_ Occupation/Role: \_\_\_\_\_

Length of service in current position: \_\_\_\_\_

**Reason for Referral:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Issues/specific questions to be addressed:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has the employee been seen here before? Yes / No

***Please advise the employee to bring relevant clinical/scan reports, if any, to the consultation.***

***Would you like to receive a call from our Specialist Occupational Health Physician prior to issuing the report?***

***Please tick: YES / NO***

Contact/Address for Invoice: \_\_\_\_\_

**Please send the completed form to [info@ohmi.ie](mailto:info@ohmi.ie)**